REQUEST TO ACCESS PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

File	Number:				

As a parent, guardian, or personal representative you have the right to request to inspect the Medi-Cal records of the individual you are authorized to represent. You also have the right to request copies of the records. You will be charged for the cost of copying and postage for some records. You will receive a response to your request within 30 days after we receive your request and payment. If you want copies of your records mailed, you need to send us a photocopy of your California driver's license or other listed identification and documentation verifying your authority to represent the stated individual. You will also need to send documentation verifying your address, such as a utility bill displaying your address. Mail this completed form to:

Department of Health Services
Office of HIPAA Compliance/Payment Systems Division
MS 4721, P.O. Box 997413
Sacramento, CA 95899-7413
(916) 255-0691

INDIVIDUAL WHOSE INFORMATION YOU ARE REQUESTING						
LAST NAME	FIRST NAME	MIDDLE INITIAL				
ADDRESS	CITY/STATE	ZIP CODE				
BENEFICIARY ID NUMBER	DATE OF BIRTH DATE OF		DEATH			
DEATH CERTIFICATE MUST BE ATTACHED						

DIRECTIONS

Please read the following before completing this form. If any of the conditions set out below apply to the beneficiary you are requesting information about, you do not need to fill out this form.

He/she has a personal injury case and Medi-Cal has paid for services related to the injury and you want information about these services and/or payments, or

He/she is requesting access to records on behalf of a deceased Medi-Cal beneficiary in order to repay Medi-Cal for services received by the deceased beneficiary. He/she may have received an Estate Recovery Questionnaire in the mail, or

He/She is involved in a worker's compensation case in which Medi-Cal has paid for services for the injury he/she received while on the job.

To get information for a Medi-Cal beneficiary recovery case, please call (916) 650-0490.

If the beneficiary is a member of a Medi-Cal Managed Care Plan, please contact his/her plan for access to his/herr medical records.

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PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE INFORMATION							
LAST NAME:			ST NAME:		MIDDLE INITIAL:		
ADDRESS:		CITY	//STATE:		ZIP CODE:		
DAYTIME TELEPHONE NUMBER: ()	EVENING TELEPHONE NUMBER: ()		EMAIL ADDRESS:	BEST HOURS TO REACH YOU:			
WHAT LEGAL AUTHOR INDIVIDUAL ABOVE?	RITY DO YOU HAVE	ЕТО	REQUEST HEALTH INF	ORMA	TION OF THE		
☐ PARENT	[□ C	ONSERVATOR				
☐ GUARDIAN			☐ EXECUTOR OF WILL				
☐ MEDICAL POWER OF ATTORNEY ☐ OTHER							
PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A DECEDENT'S WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.							
PROTECTED HEALTH INFORMATION YOU WANT TO ACCESS							
WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?							
☐ CLAIM DETAIL REPORTS, which show clain paid by Medi-Cal for services received. (\$25 fee) ☐ TREATMENT AUTHORIZATION REQUEST SCREENS. Printouts show which providers have requested services, which services were request the decision about the service(s), including a sim description of the decision, and whether the provides billed for these services. (No fee) ☐ CASE MANAGEMENT RECORDS, which she case manager notes. (No fee)		ed, ole der	Managed Care Records:				

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FOR WHAT TIME PERIOD DO YOU WANT INFORMATION?				
FROM DATE	TO DATE			
METHOD TO ACCESS YOUR PROTECTED HEALTH INFORMATION				
☐ PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION.				
☐ I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON.				
☐ I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT MY RECORDS.				
NAME				
TELEPHONE NUMBER ()				
ADDRESS				
RELATIONSHIP TO YOU				
IF YOU REQUEST TO REVIEW RECORDS IN PERSON YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.				
LOCATION AVAILABLE FOR IN PERSON REVIEW SACRAMENTO ONLY				

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IDENTIFYING INFORMATION						
☐ COPY OF IDENTIFICATION ATTACHED						
(CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD)						
NUMBER						
I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.						
BENEFICIARY SIGNATURE		DATE				
(IF NO IDENTIFICATION IS ATTACHED YOUR SIGNATURE MUST BE NOTARIZED.)						
NOTARIZED BY	_ON	(DATE)				
NOTARY PUBLIC NUMBER						
UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC						
☐ ADDRESS VERIFICATION ATTACHED						
FORM OF ADDRESS VERIFICATIONLICENSE, ETC.)		_ (UTILITY BILL, PHONE BILL, DRIVER'S				

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.

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